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BOLSTERING CHANGE: PHYSICIAN COMPENSATION FOR QUALITY AND VALUE

By Alice G. Gosfield, Esq.

Alice G. Gosfield & Associates, PC
2309 Delancey Pl.
Philadelphia, PA 19103
215-735-2384
215-735-4778
agosfield@gosfield.com
www.gosfield.com

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Bolstering Change: Physician Compensation for Quality and Value

Alice G. Gosfield

_.1 Introduction

Since the passage of the health reform legislation (Patient Protection and Affordable Care Act)[1], in very short order, it has become almost a truism that payment to providers in American health care is changing to reward the value of health care services rather than their volume.[2] This is true for hospitals facing the value-based purchasing (ñVBPò) program in Medicare[3] as well as for patients in commercial insurance programs who face benefit design which motivates them to choose higher value providers.[4] As a result of health reform, other types of providers will increasingly be the targets of these efforts, beginning with Medicare's transparency programs which are also intended to help patients choose their providers based on quality and value, including skilled nursing facilities, home health agencies, dialysis centers, as well as hospitals and physicians.[5]

But potentially the most significant focus has been directed at physicians, and for good reason. Although some might view the notion as 'physician exceptionalism', in fact, physicians play a unique role in American health care[6]. Virtually everything that happens in a hospital is the result of a physician order. Physicians are primary determinants of where the patient will go to receive additional care, whether from specialists, hospitals, or ancillary service providers like imaging centers, home health agencies, and rehabilitation providers. Notably they have been paid traditionally in ways that are not in synch with the new value on value[7]: fee-for-service payment motivates overuse of services and without regard to either the impact of those services on the ultimate outcomes for the patient, nor the quality of the processes brought to bear in treating patients. Today, a significant number of primary care physicians believe that the patients

[1] Pub. L. No. 111-148 and Pub. L. No. 111-152, the Consolidated Print. (Hereafter ñHRò)

[2] Gosfield, "The New Value on Provider Value", HEALTH LAW HANDBOOK, (2011 ed.) WestGroup, A Thomson Company, pp. 1-34 (hereafter ñGosfield on Valueò).

[3] HR § 3001; 76 Fed. Reg. 26490 (May 6, 2011).

[4] Houy, ñValue-Based Benefit Design: A Purchaserôs Guide,ò NBCH (Jan. 2009) http://www.sph.umich.edu/vbidcenter/publications/pdfs/VBBDPurchaserGuide%5B1%5D.pdf

[5] See Gosfield on Value, supra n. 2. All of the Medicare Compare websites can be accessed through http://www.medicare.gov

[6] Gosfield, ñPhysicians Leading Change: Towards What End?ò Maryland Medicine, 12:3 (2011) pp. 10-12; Gosfield and Reinertsen, ñAchieving Clinical Integration with Highly Engaged Physiciansò (2010) http://www.uft-a.com/PDF/ACI-fnl-11-29.pdf

[7] Gosfield on Value, supra n. 2.

in their own practices are receiving too many services; and they are sure that other physicians are delivering more than they should as well.[8] By the same token, there is no evidence that much progress has been made in ameliorating the problem of Americans getting only 55% of what the evidence says they should be receiving in treatment.[9]

It is clear that physicians, in their unique roles, are not yet providing either what policy and the market say we want in health care, nor what Congress has mandated to happen, certainly not in Medicare or Medicaid. It seems even more important today to look at the incentives targeted at physicians to bolster more rapid movement to better performance with a better economic result as well. Overuse costs money and can harm patients. Continuing improvement both in terms of outcomes as well as costs are the goals of the new environment. Some health systems which employ physicians and some significant physician groups across the country have already headed that way. Virtually every commentator projects that productivity based compensation will not be the bedrock approach to physician compensation that it is today.

This chapter looks at the new drive for improved physician value performance, including new revenue opportunities which stem from legislative incentives to motivate changed physician behavior on several fronts. It considers recent history as to how physicians have been compensated in their individual compensation for quality. It offers information from a recent survey of medical groups I conducted in follow up to the one I did in 2007,[10] as well as data from several recent surveys of hospital or system employers regarding how they compensate their physicians. As hospitals increasingly employ physicians, the compensation challenges to align the care for patients between hospitals and physicians face some barriers not present in the physician group practice. Still, there seems to be a lot of room for health systems and hospitals to learn from physician groups that lead on these fronts. Finally, this chapter concludes with a review of the legal issues that must be taken into account in structuring physician compensation which rewards quality and value.

_.2 Context

There is no question that the expansion of pay for performance programs and publicly reported performance measurement which preceded health reform have contributed to moves to take into account quality performance in physician compensation. As we will see below, particularly in California, the activities of the Integrated Healthcare

[8] Sirovich, Woloshin and Schwartz, ñToo Little? Too Much? Primary Care Physiciansô Views on US Health Care,ò 17 Arch. Intern Med 1582-1585 (Sept. 26, 2011).

[9] McGlynn et al, ñThe Quality of Health Care Delivered to Adults in the United States,ò 348 NEJM 2635-2645 (Jan. 26, 2003); Maugh, ñNearly 70,000 Americans die needlessly each year because they are not given optimal heart failure therapy,ò Los Angeles Times (June 6, 2011).

[10] Gosfield, ñCompensation For Quality: The Next Inevitable Step,ò Group Practice Journal (May 2008) pp. 10-15; Gosfield, ñPhysician Compensation for Quality: Behind The Groupôs Green Door,ò HEALTH LAW HANDBOOK (2008 ed.) WestGroup, A Thomson Company, pp. 1-44.

Association with its pay for performance program based on common measures among plans, has fueled new compensation approaches. But the acceleration in today's interest in new compensation models comes from the implications of the new initiatives in health reform.

_.2.1 **Health Reform Payment Innovations**

The pressures created by health reform to change physician compensation do not come from any physician payment reform in the legislation. There was none. Rather it is in the reorganization of health care delivery because of other payment reforms that the changed demands are seen. These have generated more attention throughout the industry to changing physician compensation models away from the traditions of either a guaranteed salary or productivity-based payment, which rewards more services and more expensive services, particularly when the measure of productivity is work relative value units (wRVUs).

The first initiative which has garnered far more attention than it deserves, is the Medicare gainsharing accountable care organization (ACO) opportunity referred to in the legislation as the "shared savings program."[11] This program is not a pilot or a demonstration. It is merely an opportunity in the legislation for hospitals and physicians to come together to be accountable for an assigned panel of Medicare beneficiaries. Paid on DRGs or fee-for service, participating hospitals and physicians respectively have to have a vehicle to accept Part A and Part B gainsharing monies which they would distribute among the provider participants. Obviously the only way to succeed in this program is if physicians manage care more effectively so that patients do not utilize too many services.

When the proposed ACO regulations were published, the Center for Medicare and Medicaid Services (CMS) announced that they expected there would be between 75-150 ACOs nationally.[12] The proposals themselves were met with excoriating reviews, including a complete walk away by all of the groups that had participated in the Medicare Group Practice Demonstration on which the ACO legislation was based and supported by the American Medical Group Association (AMGA).[13] Shortly thereafter, CMS announced two additional pathways to become either a Pioneer ACO or an Advanced Payment Initiative ACO.[14] The first was designed for up to thirty organizations nationally who were likely close to functioning ACOs already, while the second was

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[11] HR § 3022; 76 Fed. Reg. 67802 (Nov. 2, 2011). See also Berwick, ñMaking Good on ACOôs Promise ï The Final Rule for the Medicare Shared Savings Programò NEJM (2011); 365: 1753-1756 (Nov. 10, 2011).

[12] Washington Health Policy Week in Review: ñACOs in the Real World: HHS Envisions Lots of ôUnicornsôò (April 4, 2011) http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2011/Apr/April-4-2011/ACOs-in-the-Real-World.aspx

[13] Daly, ñAMGA Pans Proposed ACO Regulationsò; Modern Healthcare (May 11, 2011). Gold, ñôPoster Boysô Take a Pass on Pioneer ACO Program,ò Kaiser Health News (Sept. 14, 2011).

[14] http://innovations.cms.gov/initiatives/aco

intended to provide financial assistance to organizations seeking to become ACOs. With the publication of the final regulations, there was some additional tepid positive response, but it is unlikely there will be 75 ACOs under the legislation. The program embodies the idea of bundled payment at the provider level, which means after the payment by Medicare as usual, it will be up to the participating providers to figure out how to divide up any of the savings they may have earned.

By contrast, the Center for Medicare and Medicaid Innovation (CMMI) announced a bundled episode based payment pilot which essentially called on providers to define the episodes for which they would be measured and paid, define the conditions for which they are playing and propose the payment methodology to be applied.[15] The program offered four different approaches -- one for truly integrated health systems taking prospectively paid full risk, one for hospitals alone, one for the thirty days post discharge to prevent readmissions which is primarily a physician-only opportunity, and the last replicating in many ways the PROMETHEUS Payment® model,[16] which would link hospitals and physicians for payment purposes through one payment or one budget which the hospitals and physicians would have to parcel out, as they would propose. Here, again, while the scope of the undertaking for providers is far smaller than the ACO approach, and the pilots will be self-determining, the basic incentive is for physicians to deliver and order services in a more value-driven way. In addition, CMS has announced a primary care collaboration between Medicare and private payors to stimulate stronger continuity of care in primary care as well as a new payment innovation to test a gainsharing approach to primary care.[17] Here, too, changed physician behavior will be a key to success. This is separate from a bundled payment pilot program which is to be implemented by January 1, 2013,[18] to integrate care around an episode of hospitalization including three days prior to the hospitalization and thirty days post-discharge. Services must include the full continuum of care including inpatient, outpatient, home health, skilled nursing and rehabilitation care. Payment will be made to a single entity which must then allocate the dollars across the participating providers. Again, the physiciansô issue will be both to improve their own quality and efficiency, but also to order services in a way that fulfills the goals of avoiding the existing incentives in fee for service payment.

_.2.2 Additional Revenues for Change

In addition to motivating physicians to change their behavior by virtue of linking what they do to other providers, by bundling payment or in episode payments, health reform and its near predecessors created other sources of revenues for physicians if they were to adopt more value-driven approaches.

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[15] http://innovations.cms.gov/initiatives/bundled-payments/index.html

[16] http://www.hci3.org

[17] http://innovations.cms.gov/initiatives/cpci/index.html

[18] HR § 3023 as revised by § 10308(b)(1).

CMS launched the Physician Quality Reporting Initiative (PQRI) as a way to get physicians used to reporting quality-relevant data on their claims.[19] Physicians who reported would receive bonuses in the form of an additional 2% on the amount Medicare paid them in a year for their services. The actual quality of the services reported is quite irrelevant. It is the reporting alone which is rewarded. A physician could deliver terrible care, but report effectively about it and still be rewarded. Congress expanded and solidified the program in health reform adding more dollars for successful reporting and then shifting to penalizing physicians who would not report in the out years.[20] To motivate physicians to engage more fully with information technology, payments are also available for meaningful use of electronic health records[21] as well as for the deployment of e-prescribing.[22] These programs not only are intended to foster change, but they also provide additional revenues. For the purposes of this discussion, those revenues can fund payments within physician practices to individual physicians for metrics the group believes will enhance their success in the developing environment.

One of the biggest motivators of change will be a program not yet implemented but for which prudent medical groups and health systems will be positioning themselves now; and that would be the value-based purchasing modifier to be applied to payments made on the Medicare Physician Fee Schedule beginning in 2014.[23] Beginning with quality measurement initially, the program will, in two years, add efficiency measurement as determined in a new publicly transparent episode grouper.[24] Those physicians who perform better on composite measures of quality will be paid more than physicians who do not score well. The fact that this program will not even be implemented for several years, also points to the fact that fee-for-service payment, as ineffective as it has been at providing high quality care at contained costs, is not going away any time soon.[25]

_.2.3 Commercial Payment Innovations

Commercial pay for performance programs were created primarily to move the pace of change to higher quality faster than history demonstrated physicians would change on

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[19] For a broader discussion of PQRI and its transformation to PQRS and the implications of that program see, Shay, "PQRS And Its Penumbraò:, HEALTH LAW HANDBOOK (2012 ed.), pp. _____

[20] HR § 3002.

[21] See Shay, supra n. 19 for a discussion of the overlap and implications of meaningful use with PQRS payments.

[22] http://www.cms.gov/ERxIncentive

[23] HR § 3007

[24] HR § 3003, for a discussion of the context for the episode grouper see Gosfield on Value, supra n. 2.

[25] Terry, ñFee for Service: How Long Will It Be Around,ò Medscape Today (10/04/11) http://www.medscape/com/viewarticle/751386

their own.[26] In the commercial sector there is also significant focus on changed approaches to paying for care.

In March, 2009, America's Health Insurance Plans (AHIP) published a report on innovations among its health plan members to recognize and reward quality.[27] Considered the leading edge of commercial plans making inroads to payment change, the report highlighted fifteen plan sponsored physician payment programs and 7 hospital recognition programs. By 2011, after the CMS ACO regulations debacle, commentators were reporting that commercial ACOs might actually lead the way in developing new models, eclipsing the regulatorily hidebound Medicare shared savings program. Citing announcements by Anthem and an IPA in Santa Clara California, CIGNA and Piedmont Physicians Group in Atlanta as physician-plan collaborations, Aetna and Carilion Clinic in Roanoke and Humana and Norton Healthcare in Louisville, as hospital-plan initiatives, VISTA Health System and Central Jersey Physician Network in Summit, NJ as a physician-physician effort, and Methodist Health System and Texas Health Resources in Dallas as hospital-hospital collaborations, reports cite these efforts to develop commercial ACO platforms upon which to change care delivery.[28] Blue Cross of Massachusetts has touted its "Alternative Quality Contract," which provides an episode based payment, which they refer to as a global budget, which the providers negotiate with Blue Cross.[29] Bonuses of up to 5% can be earned based on quality. Physicians are paid fee for service and all services to the patient, whether in the quality payment network or not, are debited against the budget. Initial reports were favorable with improved quality and generated savings.

The PROMETHEUS Payment® model design was begun in December 2007. It was launched in pilot demonstrations under a Robert Wood Johnson Foundation grant which concluded in February, 2011. A RAND evaluation reported on the difficulties that the pilots had in implementing the bundled budget model based on Evidence-informed Case Rates® which defines the PROMETHEUS Payment method.[30] The evaluation reported on difficulties with claims data, slow pace of implementation and a variety of other challenges. The snapshot which informed that study, however, predates improvements in a variety of aspects of the program which continues to be implemented around the

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[26] See Gosfield, ñContracting For Quality: Then, Now and P4P,ò HEALTH LAW HANDBOOK (2004 ed.) pp. 103-182.

[27] AHIP, "Innovations in Recognizing and Rewarding Quality" (March 2009) http://www.ahipresearch.org/pdfs/P4PMonographWeb.pdf

[28] Tocknell, "Commercial ACOs May Find Footing Where CMS Slips", Health Leaders Media (Aug 31, 2011)

[29] Chernew, et al, "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract' ", Health Affairs (Jan 2011) pp 51-60

[30] Hussey, Ridgely and Rosenthal, "The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems in Implementing New Payment Models", Heath Affairs (Nov 2011) pp. 2116-2124

country, now including Medicaid in New York and a statewide implementation in Colorado.[31]

The point of all of this is that while health reform has created a furor of activity in the public programs, for providers, the pressure is coming from all corners to do something significantly different. The context for the delivery of care for hospitals is changing, but they are already predominately paid on DRGs which motivate a certain degree of attention to managing costs. And while their need to focus on patient safety, avoiding adverse events and avoidable readmissions is clear, it is for physicians that the coming changes will be most radical.

_.3 Historical Background

In 2007, there was almost nothing in the published literature about whether physicians were being paid anywhere, in their compensation as individuals, within their groups or by other employers, for better quality performance. I had speculated that maybe the reason reported results of the impact of P4P programs were so tepid was that the money being paid wasn't actually getting into the wallets of the physicians whose behavior the payment was intended to motivate. When I started asking about this among medical group executives whom I knew, Nick Wolter, MD, CEO of the Billings Clinic suggested the issue was important enough to get the American Medical Group Association to distribute a survey asking about the prevalence of these approaches to payment. They graciously agreed to do so. Of the then 345 members of the AMGA, only 13 provided responses; and I spoke with many of those answering.[32] Astonishingly, to me at least, there were a number of responding groups which had been paying their physicians, in some measure, for better quality performance for well more than ten yearsð at that time. Most of the respondents had been at it between 2 and 7 years. Others had just started to test some new compensation models. So, there were three historically separate versions of these programs. All reported that their quality improved, but all said it was not because of the compensation alone, but rather that the compensation fit within a setting of broader strategic efforts to improve quality performance.

In developing and implementing these models, there were common lessons learned. Unrolling the program gradually, beginning with reporting quality performance within the group before applying any financial consequence, was uniformly suggested. Transparency of results within the group was cited as contributory to both credibility and changes in behavior. The groups who had been doing this the longest had moved, over time, from process measures to intermediate outcomes measures. Groups in markets where managed care was a strong presence reported coordinating their internal measures

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[31] de Brantes, "That Was Then. This Is Now", (Nov. 2011) http://www.hci3.org/sites/default/files/files/ThatWasThenThisIsNow-2011-11-10.pdf

[32] The initial report of the survey was published in the Group Practice Journal of the AMGA, supra n. 10.

with external HEDIS measures, which NCQA would use to rate the health plans with which they participated.[33]

For the next few years while the literature focused on P4P programs, patient-centered medical homes, and potential changes in Medicare reimbursement because of rising costsð with the perennial problem of what to do about the impact of the sustainable growth rate (SGR) applied to the Medicare fee scheduleð there was still virtually nothing published about groups compensating their physicians as individuals for their quality performance. Then, in 2009, a paper was published reviewing data from 2007, the same timeframe as my non-scientific survey.

In a study of large medical groups of more than twenty physicians, Robinson, Shortell and their co-authors looked at the prevalence of pay-for-performance bonuses paid to those groups and then the payment methods used by those groups with specific reference to quality and patient satisfaction based compensation. [34] They identified the groups to which to send their survey based on information from the Medical Group Management Association, Dorland Healthcare Information, and the Integrated Healthcare Association which is a California based organization. They did not consult the AMGA which includes some of the oldest multi-specialty physician groups in the country, many of which have evolved to systems of care where the hospitals are a product line within the medical groups as with the Mayo Clinic, Scott and White, Park Nicollet and the Billings Clinic. The AMGA also includes a few IPAs among their members.

After identifying a total eligible population of 581 groups, they conducted 35 minute structured interviews with a senior administrator. Interviewees were reimbursed $150 for their time. A total of 339 medical groups participated. The investigators looked at the extent to which the groups were paid capitation as a proxy to determine if the groups were at risk for managing the costs of care, as opposed to fee for service payment. To determine the extent of payment for quality, they asked whether the group participated in Bridges to Excellence, a multi-payor P4P program, and also whether the groups participated in any of three of the Institute for Healthcare Improvement's (IHI) programs the Quality Collaborative, Pursuing Perfection, and Improving Chronic Illness Care; but none of these has a payment component. Rather participation in these programs stood for the proposition that the group was oriented toward improving quality generally.

Slightly more than half of the groups received some additional revenue from health plans based on quality or patient satisfaction. Based on how they identified their participants, however, this report would indicate a distinct skewing toward California which has the Integrated Healthcare Association initiative, although none of the data in the study was actually reported geographically. Even in their cohort though, capitation had declined to

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[33] A broader discussion of the results, the context for payment generally at that time, and some speculation about developing payment models was published in my 2008 HEALTH LAW HANDBOOK article, supra n. 10.

[34] Robinson, Shortell, Rittenhouse, Fernandes-Taylor, Gillies and Casalino, "Quality-Based Payment for Medical Groups and Individual Physicians, " Inquiry (Summer 2009) pp 172-181

cover only 8% of the patients treated by these groups. Capitation is even less prevalent as a payment model across the country.

Based on data from March 2006-March 2007, they found that about one-fourth (27%) of the medical groups paid their primary care physicians and one fifth (19%) paid their specialists at least some portion of their compensation based on quality and or patient satisfaction. They found that groups which received external payments for quality or patient satisfaction were more likely to pay their physicians on that basis as well. Not surprisingly, although productivity was the predominant form of payment across groups, where groups were largely paid by HMOs on a capitated basis, their physicians were more likely to be paid a straight salary and not on productivity. Because they were primarily studying prevalence of external and internal payment models taking into account quality or patient satisfaction, there are no lessons learned reported, nor any discussion of the implications, other than to observe that where external payment motivates behavior, it is likely that internal payment will evolve to be consistent, "consistent with the economic literature on payment incentives which highlights the importance of mechanisms that reward both individual and cooperative efforts and that compensate improved performance without putting the recipient at financial risk for outcomes he or she cannot control."[35]

_.4 Current Information

In the current setting, where the measurement of performance will affect all providers, physician groups and hospitals employing physicians have demonstrated renewed interest in how to more closely align their activities to produce quality results which will now have financial impacts. What is going on today?

_.4.1 Physician Group Compensation Reports

Four years after the data from my survey and from the Robinson Shortell study, it seemed useful to take another look at the evolution of physician compensation. In addition, as ówalueô itselfð paying attention to the cost of care as quality is enhanced ï has become a more predominant factor, what compensation models might be focused there? The AMGA agreed once again to distribute a brief survey to its 385 member groups.[36] The following questions were asked in an electronic format:

1. For how long has quality performance been a factor in determining physician compensation in your group?

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[35] Id at 179

[36] The first report of the survey was published, as in 2008, in AMGAôs Group Practice Journal special issue on compensation, including topics such as their analysis of their own survey of compensation trends, thinking about physician compensation in an accountable care environment, and designing compensation models that appeal to younger physicians . Gosfield, ñCompensating Physicians for Quality and Value: A Changing Landscapeò, Group Practice Journal (Sept 2011) pp. 18-26

2. Please describe your current approach or attach a written description used in the group.

3. If your approach has evolved over time, please briefly describe the stages your group went through to get to the program/metrics that you use now.
   How much of the physicianôs compensation turns on these metrics? How has that evolved?

4. Do you consider óvalueô as a factor in compensation? (e.g., bonuses or additional payment for less resource-intense services, shorter lengths of stay, use of less-expensive treatments first.)

   If Yes, for how long has this been a factor in compensation?
   If Yes, what percentage of the compensation turns on value performance?
   If Yes, please describe the metrics and approach or attach what you use within the group.

5. Have you ever terminated a physician for not having achieved threshold performance on your quality or value metrics?

6. Please describe the impact of these programs in changing physician behavior or performance results of the group.

7. What lessons did you learn in implementing these types of programs?

8. Have you ever used the existence of these programs or their results in marketing to the public or your patients? Please describe.

9. Have you ever used the results of these programs or their existence in payor negotiations? Please describe.

Almost three times as many groups responded (35) as had in 2007 (13), but some of those who responded then did not participate in 2011. Still further, some groups answering in 2011, had been doing this a long time but had not responded in 2007. Two respondents were IPAs which were not the focus of the inquiry and their data was excluded. Seven groups said they were doing nothing and paid based on productivity alone. Their answers werenôt tabulated in any way, since all I was interested in were models that did compensate for quality and value. The responses of those saying they paid on productivity alone leads, inevitably, to the conclusion that even among AMGA members, the majority likely still compensate for productivity alone ï a model which is decidedly at variance with new organizational and reimbursement goals. In fact, a recent examination of this issue found that among high performing practices, including some of the biggest names in health care, such as Henry Ford Medical Group, Intermountain Health, Lahey Clinic and Ochsner Clinic, productivity is still the predominant compensation model.[37]

[37] Kelley, ñProductivity Still Drives Compensation in High Performing Group Practices,ò Health Affairs Blog (Dec. 20, 2010) http://healthaffairs.org/blog/2010

But some payment for productivity has to be taken into account in any group practice, if capitation is decreasing as a compensation model. Fee for service requires that some threshold of production be maintained or the financial model is unsustainable. Even where salary alone is the compensation model, in a fee for service world, the amount of that salary has to be constructed around an expectation of volume and mix of services paid on the fee schedule. For some health systems taking population based risk paymentsð of which there are very few nationallyð construction of physician compensation raises similar challenges as in a capitation model. In capitation the perverse incentive is underserviceð the less you do, the more of the capitation dollars you get to keep.

Similar to the analysis in 2007, I found that there were three ótranchesô of longitudinal experience among the 26 groups who remained after the exclusions noted above: 8 groups had just begun and had compensated their physicians on quality for two years or less; 6 groups had been at it between 3 and 6 years, and 12 groups had been compensating their physicians for quality performance for more than 10 years. Obviously, among those who had responded in 2007, four years later mid-range adopters then had now moved into the long-standing category.

Unlike the Robinson Shortell survey which did not report its data geographically and also relied in part for identification of study subjects on information from the California-restricted IHA, respondents to the AMGA survey were from all across the country including markets where managed care has been a powerful force for a long time, and integrated systems are more prevalent, such as Minnesota, California, Washington and Oregon. Even among those respondents, however, some groups have longstanding programs but others have just begun, which calls into the question the extent to which external payment, which groups in the same states would be more likely to experience, motivate these programs. Respondents also were from Michigan, Massachusetts, New York, Florida, Iowa, Montana, Tennessee, Wisconsin, Ohio, the District of Columbia and Maryland, and Pennsylvania. One of the 2011 respondents with a long-standing program which did not answer in 2007 was from North Carolina. Three groups who are in the long-standing category of more than ten years, did not answer in 2007. Of the 7 groups who have been compensating physicians for quality between 3 and 6 years, four would not have answered in 2007 because they have not been doing it long enough.

While many of the respondent organizations are integrated systems, where the hospital and the physician group are part of the same corporate entities, whether in sister corporations or under one legal umbrella, some were stand alone multi-specialty groups, and two were pediatric groups. The message here is that compensation for quality can thrive regardless of the practice setting.

Among the recent adopters with programs no older than two years, several reported beginning with reporting within the group for a full year with no financial consequence imposed until the physicians were comfortable with the measurement system and believed in its credibility. Some, as in 2007, reported focusing on one set of metricsð

improved diabetes care, rather than multiple clinical topics. Most began with primary care. Respondents in this category reported a range of 3%-7.5% of base salary at risk for quality. Some describe it as a bonus and some as a withhold. Others pay a fixed stipend for participation in quality projects. Several cited the opportunity to earn a bonus based in part by attending meetings of the group. In these settings, it was believed, physicians had become isolated from each other, and attending meetings would bolster a true group culture and a better understanding of the goals of the enterprise ï and that has worked. In terms of effects on quality itself, one group reported that from the inception of their program with one year of no financial impact to the end of two years with financial impact, with 7.5% of base salary now at risk for quality, their medication reconciliation rate improved from 26%-71%.

Very few in this group reported rewarding value ï cost effective care processes. But one group said 1% was at risk for value and another reported using value measures such as length of stay, readmission rates and utilization of order sets by their hospitalists who have 10% of their compensation at risk. That group, which has used this approach for only two years, reports wanting to move to a minimum of 25% of compensation at risk for quality and value next year! All the recent adopters reported that the programs have impact on performance. They cite transparency of results reported within the group as contributing to impact. While all reported planning to use their data in negotiations with their payors, none had yet done so, although some have said their payors are impressed with the work. There was a little implication of some frustration with payor response. Reporting groups in this tranche include Sentara Medical Group in Virginia, Mayo-Owatonna in Minnesota, Sutter Gould Medical Foundation in California -- both of which are parts of systems which permit a degree of self-determination regarding compensation even though they are part of a single ósystemô of care delivery ï Olmstead Medical Center in Minnesota, Henry Ford Medical Group in Michigan, Wenatchee Valley Medical Group in Washington and Bozeman Deaconess Medical Group in Montana.

Among the mid-range adopters who have been paying for quality for between 3 and 6 years, those with longer histories have more compensation at risk than the younger programs. At the lower end, groups report between 1-2% at risk, another 3% and a third 5-10%. At the higher end, groups put 4-7% of compensation at risk for quality or use a stipend ($10,000 performance incentive with half based on quality and the remainder on meeting attendance, citizenship standards and OSHA compliance). These groups report more specialty-specific metrics, such as asthma action plans and spirometry in a pediatric practice. Improving internist and family physician colonoscopy rates in patients over 50 was reported in a multi-specialty group. Another group that uses specialty-specific metrics generally, has added a clinic-wide customer service metric as well. Other metrics are less about quality itself and more about those vehicles that will improve quality such as patient satisfaction scores, participation in meetings and committees, and timely closing of visit encounters in the EMR. Few report having changed the amount of money at risk over time. This is especially interesting since many of those who answered in 2007 said that there had to be between 5% and 10% at risk to get the attention of the physicians.

Two of these groups reported rewarding value-based behavior with incentives of 2-4% at risk, one citing their hospitalist program in particular. In another group, senior physicians are eligible for annual incentive payments for achieving or exceeding budgeted margins for their practices. In terms of impact, all report some positive change including reduced emergency department visits. One group cited the bonuses as enhancing their implementation of EMR. These groups seemed to report better traction with their payors recognizing the results they have demonstrated. Included here are Advocate Medical Group outside Chicago, Illinois, Mount Kisco Medical Group in New York, Summit Medical Group in Tennessee, the Iowa Clinic, Pediatric Associates in Florida, Childrenôs Primary Care Medical Group in California, and the PeaceHealth Medical Group in Washington.

Those who have been conducting these programs for more than 10 years I have referred to as ñpioneersò in other writings. The 12 groups in this 2011 cohort (with one having been paying physicians for quality for 16 years) obviously have more longitudinal data to offer. Only two of those who were in this group in 2007, did not report in 2011. Unlike the short-term and mid-range adopters, most of these groups have contracts that pay them for their quality results at a minimum. The groups in California, not surprisingly, have the most of this, although other groups including in Michigan report a greater variety of reimbursement with some all risk arrangements, some pay for performance and some payment for medical homes as payment models. The most shocking information in this group, though, came from the Everett Clinic in Washington, which was a pioneer group in 2007 and had then been compensating its physicians for quality for more than 10 years. In 2011 they did an about face and decided to pay only for productivity. The reporter for this group, a physician in senior leadership said, ñThere is an aphorism in physician compensation that the best compensation model is the next one you will use.ò He attributed the reversal to a change in both the governance of the Clinic and how compensation was approved as part of governance. In addition, a concern over complacency within the group regarding hard work was cited.

Here, again, most do not report having changed much of the amount at risk over time although the range is considerable, from 3% at risk to 15% at HealthPartners in Minnesota which rewards participation in improvement activities as well as quality outcomes. Geisinger, which had in 2005 published the only report I could find on the topic,[38] has refined its model over time, balancing groupwide and individual metrics. Group performance data are shared at Geisinger, but individual performance measures are not. Healthcare Partners Medical Group in California continues to focus only on primary care in its quality compensation and continues to track to the HEDIS measures on which its plans are measured.

The Billings Clinic was a mid-range reporter in 2007, but has now been doing this for more than 10 years. They have 12 specialties paid in part on their quality performance, along with primary care. Billings uses a combination of approaches with 3% at risk for some specialties and lump sum stipends paid to others. The specialties have long set their

[38] Bisordi, Hanory and Pierdon, ñPaying For Performance: Establishing the Culture, Evolving the Concept,ò Group Practice Journal (Sept. 2005) pp. 20-24.

own metrics, and as early as 2007 I reviewed measures for the radiology department; so their program is not limited to the types of care that are typically cited as needing improvement. To my way of thinking, this is a manifestation of their very strong culture that improvement for quality and efficiency is a core focus of the entire enterprise. In fact, unlike many of the other groups, they do measure and reward for value as for example in cardiovascular surgery in terms of reduced hospital readmissions, blood usage and length of stay.

Three groups among the 2011 respondents had not responded in 2007 and today have been compensating for quality for more than ten years. Two focus on primary care, only with one having 5% of base compensation at risk and the other 10%. The third group started with primary care only but has added specialists

All of these groups keep an eye on external measures, but it is not what drives the programs. However, to the extent they are measured and reimbursed on quality metrics they believe it is only logical to be consistent with their external payor sources. All report that compensation for quality is part of a far deeper quality-driven culture, so that performance that is rewarded in compensation is part of other fundamental operating principles of their organizations. A good number of the organizations reporting in this group were also organizations described as high value high quality health care delivery systems during the health reform debates.[39] Some in this group are considering putting more compensation at risk for quality and value. None anticipates terminating the approaching or decreasing the amount at risk. In addition to the groups named above, this tranche includes MedStar Physician Partners in the Washington, DC area, IHA in Michigan, PriMed Physicians in Ohio, Sutter Medical Group, First Health Physician Group in North Carolina, and Thedacare in Wisconsin.

Contrary to the assumptions in the Robinson Shortell study, most of the groups responding did not report that external payment was the reason for initiating these programs, because, indeed, many were started before there were any external payment models to reward improvement. However, it is also clear among the longest standing programs as well as the newest initiated ones, external payment models are a very important factor in the maintenance and sustenance of these programs.

Lessons learned in the implementations are consistent with those reported in 2007. Start small. Choose well-regarded, evidence-based measures that are credible to physicians. Make sure the physicians really understand the measures before you attach compensation implications to them. Educate them about the proper documentation to score well. Periodic feedback during a compensation year can enhance impact. Transparency within the group can be important, but that is more important where there are groupwide metrics at issue. Donôt measure too much ï no more than 8-10 measures at a time was cited as

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[39] See, Crosson. ñ21st Century Health Care: The Case for Integrated Delivery Systems,ò NEJM 2009; 361: 1324-1325, and Minnott et al ñThe Group Employed Model as a Foundation for Health Care Delivery Reform,ò The Commonwealth Fund, Issue 13 Brief. (April 2010).

the largest amount that can be managed and actually obtain results. Those who have been at this for a while report that change takes time; and very clear communication regarding the goals of the program enhances the chance that the compensation component of a group practice can bolster broader strategic objectives.

Potentially the most radical departure from traditional compensation models can be found in reports from Fairview Clinic in Minneapolis, which now puts 50% of physician compensation at risk for patient satisfaction and quality scores.[40] Ten percent of the formula turns on patient satisfaction and 40% on quality scores. The system was reportedly designed by the physicians themselves. The purpose was to motivate teamwork and outcomes. The physicians had felt tyrannized by a productivity model. While there has been some grumbling, early reports are that quality is improving.[41] The system applies only to primary care physicians and is intended to shift treatment particularly in chronic care to keep people out of the hospital. In the first year the physicians were guaranteed not to lose income. There were reports that family physicians threatened to stop delivering babies if the formula wasn't changed, and some said it was complex and confusing. There has been tinkering since the initial introduction, and the final story has yet to be told. So far, in addition to quality improvement, pay has actually gone up for the family physicians under the new model. Against the background of innovation and change in physician driven groups, it is interesting to look at what hospitals and health systems are doing, as more and more physicians have become their employees.

_.4.2 Hospital and Health System Employment Models

With the rapidly increasing employment of physicians by hospitals and health systems, one would expect them to be highly focused on real alignment of physician compensation with health system goals. In my personal experience, this is extremely variable. While I have worked on a number of physician group lease arrangements, where there have been quality measures built into compensation models, that has been far less the case in the physician-employment transactions on which I have worked. In fact, many of the employment arrangements I have seen in the last two years have involved an inordinate emphasis on wRVUs with bonuses available for higher productivity. Many of the physicians, particularly cardiologists, are seeking and getting contracts which promise them higher compensation than they have been able to generate in private practice, with terms of as long as ten years. The sustainability of these arrangements in the face of the failure of the sustainable growth rate (SGR) payment model, along with the impact of the failure of the deficit reduction committee to reach any agreement, and the hospital VBP, as well as reduced payments for hospital acquired conditions and readmissions in thirty days[42] is highly questionable. As to whether these approaches are leading to changes in

[40] Herman, "Half of Physician Pay at Minnesota's Fairview Health Depends on Patient Satisfaction, Quality Scores," Becker's Hospital Review (Sept 15, 2011)

[41] Lerner, "Doctors' pay plan is cutting edge", Star Tribune (Sept 14, 2011)

[42] HR § 3008; and HR § 3025.

physician quality performance, in surveys of health system executives pursuing improved ñalignment strategies,ò leaders report that only 2% of non-employed physicians are completely engaged, and only 11% of employed physicians are engaged around quality.[43] Against that background, it is interesting to read reports of what CEOs and CFOs of health systems are saying about compensating their employed physicians.

There is certainly considerable speculation that health systems will move toward greater alignment in their physician compensation packages with what their external payment models are incentivizing.[44] Health Leaders magazine conducted a physician compensation survey which included 316 health systems employing physicians around the country.[45] An overwhelming majority (76%) of respondents indicated that Medicare and Medicaid were the number one influence on their compensation models, followed by 59% citing health reform as a critical driver. Respondent health systems indicated they are reviewing their physician compensation models more frequently, with 42% indicating change every year or two, and another 38% adjusting every 3-5 years. However, current payment models are salary plus incentive along with productivity (40% and 34% respectively). Fourteen percent (14%) of physicians in these models are paid a straight salary.

Bare majorities of respondents (57%) indicate they now ñprize quality as an incentive measureò and another 50% say they are using patient satisfaction measures to motivate physicians. Like the physician groups which include meeting attendance and participation in committees as measures for additional compensation, here 47% compensate for participation in administrative duties and 23% for chart completion. By contrast with the physician groups using quality measures who say credibility to the participants is a key factor in success, 52% of the respondents among health systems, report that physicians have little to no influence on the creation of compensation models at their organizations! The survey apparently did not ask whether the participants believed their models accomplished their stated purposes, unlike all the respondents in my survey who believed their programs had made an impact and in many instances could cite examples.

Against this rather weak series of responses with respect to either demonstration of the link between physician compensation and the broader strategic goals of the organization, or an appreciation of how incentives might actually produce results, surveys by physician recruitment firms, which bring the physicians to the systems report that ñhospitals and health organizations, have ólimiting factorsô when it comes to just how much of an influence value-based incentives can have on physician compensation. As a result, this

[43] Betbeze, ñPhysician Alignment, Collaboration, and Quality Care,ò Health Leaders (Sept. 2011) pp. 28-32.

[44] Darves, ñPhysician Compensation Models: Big Changes Aheadò , NEJM CareerCenter (Oct 3, 2011) http://www.nejmcareercenter.org/physician-compensation-models-big-changes-ahead.aspx

[45] Minich-Pourshadi, ñPhysician Compensation: Shifting Incentivesò, Health Leaders Media Intelligence (October 2011) reported in ñPhysician Comp Incentives Shiftingò, HealthLeaders (Oct 2011) pp. 28-32

shift ñtoward a more risk-based physician compensation structure is a slow and gradual process.ò[46] These limiting factors are unidentified.

It is clear that the fact of employment alone is not sufficient to generate the kind of changes that will be necessary for the hospital or health system-physician employment strategy to succeed. It does seem ineluctably true, however, that by maintaining compensation policies for employed physicians which merely replicate the status quo, the employment strategies will be as doomed as they were in the mid-nineties.

_.5 Legal Issues

The principal legal issue associated with compensating physicians for quality in their employment rests in the Stark statute.[47] The rules pertaining to physicians in groups reflect the statuteôs recognition of the permissibility of profit-sharing and productivity bonuses.[48] In the hospital context the issues are slightly different because the scope of the revenues that may be paid to the physician are somewhat more narrow.

To compensate physicians for quality or value would not cause problems under the Stark statute or regulations as long as the basis for the payment does not reflect the volume or value of ñdesignated health servicesò that the physician orders. Physicians can always be paid for the services they render themselves under Medicare. Stark only implicates referrals for designated health services that are performed by others. One could imagine that to improve diabetes care or cardiac care for chronic patients that increased clinical laboratory testing on a more frequent basis might be appropriate. As long as the compensation formula does not directly reflect the volume or value of diagnostic testing ordered, the compensation could be made to conform with the general principles in the Stark regulations. While the Stark regulations specify some methodologies for distributing profits and productivity bonuses, the preface to the regulations states:

> ñé [O]ther methods (including distributions based on ownership, interest or seniority) are acceptable as long as they are reasonable, objectively verifiable and indirectly related to referrals. These compensation methods should be adequately documented and supporting information must be made available to Secretary upon request. Under this latter ócatch-allô

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[46] Westgate, ñPhysicians Need to óEarn Their Keepô in Upcoming Compensation Modelsò, Physicians Practice (Oct 19, 2011) http://www.physicianspractice.com/conference-insider/mgma2011/display/article/14216é

[47] 42 USC § 1395nn

[48] For broader discussion of Stark regulations regarding profit-sharing and productivity, see Gosfield, ñPhysician Compensation for Quality: Behind the Groupôs Green Doorò HEALTH LAW HANDBOOK (2008 ed.) WestGroup, A Thomson Company, pp. 1-44.

provision, the group practice essentially bears the risk of noncompliance.ò[49]

In a hospital and health system setting, there are some additional challenges. Where the physicians are directly employed by the hospital itself, the only exception available under Stark for the financial relationship is the employment exception.[50] Here, any amount paid by an employer to a physician who has a bona fide employment relationship is permitted if the employment is for identifiable services, and the remuneration is consistent with fair market value, not taking into account directly or indirectly, the volume or value of any referrals by the referring physician. In addition, the remuneration must be commercially reasonable even if no referrals were made to the employer. In hospital employment, productivity bonuses are permitted but not allocation of ñincident-toò dollars or profit-sharing per se, as is permitted within group practices. While one might have thought that the fair market value issues were unlikely to merit scrutiny by the regulators, Covenant Medical Center of Waterloo, Iowa learned otherwise in August, 2009. Two orthopedic surgeons, two neurosurgeons and a gastroenterologist, the Justice Department alleged, were among the highest paid physicians in their field in the entire country making as much as $2.1 million each year. The hospital paid a $4.5 million settlement under the Stark provisions.[51] It has been unusual for the Department of Justice to focus on Stark. Initially sparked by disgruntled competing physicians who sought an injunction against the hospital, the settlement reflects the theory that false claims were filed because the compensation paid was too high.

Overcompensation aside, hospital and health systems are considering a variety of approaches to the quality and value alignment strategies.[52] Health systems can compensate physicians for their own improved quality performance and value, although they are hampered by the restriction in the statute against making a payment, directly or indirectly, to a physician to reduce or limit services to a Medicare or Medicaid patient under the care of the physician as well as a penalty against physicians who accept such payments.[53] It is this civil money penalty provision which has stood in the way of gainsharing programs without significant safeguards. Therefore, in a hospital or health system compensation scheme for physicians, reduced lengths of stays, even from a baseline of overuse would not be a good metric on which to pay physicians. By contrast, the regulators reiterated in 2007 their prior guidance that,

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[49] 66 Fed. Reg. 909-910 (Jan. 4, 2001).

[50] 42 CFR § 411.357(c).

[51] Department of Justice Press Release, Aug. 25, 2009; Biesch, ñPhysician Compensation sparks $4.5 million settlement in Iowa,ò Modern Physician (Sept. 14, 2009).

[52] Southwind Health Partners, LLC and VHA, ñHealth System Sponsored Physician Employment: Keys to Success,ò (2009) http://southwind.advisory.com/admin/editor/assets/Images%20Site%20Content/Southwind%20VHA%20Keys%20to%20success%20Part1%20v22%20nov%205.pdf

[53] 42 USC § 13.20a-7a(b)(1)(2).

> ñCompensation related to patient satisfaction goals or other quality measures unrelated to the volume or value of business generated by the referring physician and unrelated to reducing or limiting services would be permitted under the personal services arrangements exception, provided that all requirements of the exception are satisfied (for example, compensation to reward physicians for providing appropriate preventive care services where the arrangement is structured to satisfy the requirements of the exception.ò[54]

If these payments can be made to physicians who are not employed by the hospital, certainly they can be paid to physicians who are employed by the hospital.

Hospitals also face issues associated with their tax-exempt status pertaining to private inurement which are beyond the scope of this article; but compensation based on quality and value performance are unlikely to implicate those issues unless base compensation is too high.

Whether in a physician group or in a hospital employment context, the contract of employment establishes the basis for the compensation, although it is not uncommon for compensation models to change over time without necessarily amending contracts. The real issue is whether failure to perform at threshold levels of quality and/or value is a predicate for termination. None of the responding groups in the AMGA survey reported terminating any physician for failure to meet quality or value thresholds. Mostly these are seen as bonus payments. As time goes by, however, it may be that with the accelerating pressure for performance from all corners, this issue will have to be revisited.

_.6 Conclusion

The changed demand for demonstrated, improved physician performance across a range of domains is unavoidable. Productivity driven compensation can be expected to diminish as physicians are expected to alter the way in which, and how much care, they provide and order. The ñhamster wheelò of fee for service medicine which productivity models facilitate, has not provided the health care Americans want or can afford.

It is apparent that a decidedly small number of organizations have moved today to realign their internal compensation models with external forces. Those which are doing so are undertaking other significant cultural changes as well.[55] That is the point of what is happening in American health care. Precisely because physicians are so instrumental in determining all of the health care that patients receive, those who continue to reward the volume of their care will suffer as a result. By contrast, organizations which direct

[54] 72 Fed. Reg. 50146 (Sept. 5, 2007), cross referencing 69 Fed. Reg. 16091.

[55] For a self-assessment tool regarding cultural change which can be used in medical groups and hospital employment settings, see Gosfield and Reinertsen, ñClinical Integration Self-Assessment Tool v.2.0ò (2011) http://www.uft-a.com/CISAT.pdf

themselves towards an environment in which ñphysicians work together systematically, withé otheré professionals, to improve their collective ability to deliver high quality, safe and valued care to their patients and communitiesò[56] will no longer be seen as the avatars of a new wave of health care, but as the norm. We can all hope this happens sooner rather than later, but some of us can actually help these changes occur. Lawyers can be instrumental in bolstering these changes.

[56] Gosfield and Reinertsen, ñAchieving Clinical Integration with Highly Engaged Physicians,ò (Nov. 29, 2010) p. 5 http://gosfield.com/PDF/ACI-fnl-11-29.pdf